TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
John P. Hodges, DC

Respondent Name
Safety National Casualty Corporation

MFDR Tracking Number
M4-15-2566-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 14, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I received a denial for this bill, stating 'NON NETWORK PROVIDER; PYMNT ADJ/PROGRAM GUIDELINES NOT MET OR EXCEEDED.' However, this is incorrect.

Please see the attached email dated September 10, 2014 from the adjuster, giving preauthorization for this examination. Also attached is the referral form from the claimant's treating doctor, Sonia Sood, MD.

We billed a total of $2,150.00 for these services. *We received no payment from your company.* **Please issue a prompt payment of $2,150.00 to settle this claim.**"

Amount in Dispute: $800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on April 22, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 17, 2014	Evaluation by a referral doctor to determine MMI/IR	$800.00	$800.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for billing and reimbursing Division-specific services.
3. Texas Insurance Code §1305.006 outlines insurance liability for out-of-network services.
4. Texas Insurance Code §1305.103 sets out the procedures for referrals from treating doctors for network claims.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 196 – Non Network Provider
   - B5 – Payment Adj/Program guidelines not met or exceeded.

Issues

1. Did the requestor have authorization as an out-of-network provider for the disputed services?
2. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code "196 – Non Network Provider." Texas Insurance Code §1305.006 (3) states, "health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103." Further, Texas Insurance Code §1305.103 (e) states, in relevant part, "A treating doctor shall provide health care to the employee for the employee's compensable injury and shall make referrals to other network providers, or request referrals to out-of-network providers if medically necessary services are not available within the network. Referrals to out-of-network providers must be approved by the network."

   Review of the available information finds that the treating doctor on record was Dr. Sonia Sood. Submitted documentation finds that a referral to the requestor from the treating doctor was obtained. Further review of available documentation finds that the certified network for this claim is CorVel. Submitted documentation indicates that a representative of CorVel supplied approval for the requestor to provide services. Therefore, the Division finds that the preponderance of evidence supports that the requestor had authorization as an out-of-network provider for the services in dispute.

2. Per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation indicates that the requestor performed an evaluation of Maximum Medical Improvement as ordered by the Division. Therefore, the correct MAR for this examination is $350.00.

   Per 28 Texas Administrative Code §134.204 (j)(4), "The following applies for billing and reimbursement of an IR evaluation. (C)(ii) The MAR for musculoskeletal body areas shall be as follows. (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area. (-b-) $150 for each additional musculoskeletal body area." The submitted documentation indicates that the requestor performed a full physical evaluation with range of motion for the Upper Extremity and Lower Extremity to find the Impairment Rating. Therefore, the correct MAR for this examination is $450.00.

3. The total allowable for the disputed services is $800.00. The insurance carrier paid $0.00. Therefore, a reimbursement of $800.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $800.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $800.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	June 3, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.